

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036844

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8719

FILED SEP 24 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis, Missouri

Length of stay in 1b

20 Years

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION 2236 Tower Grove

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

c. CITY

St. Louis, Missouri

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

(If outside, give location) 2236 Tower Grove

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

THOMAS

First

WASHINGTON

Last

4. DATE OF DEATH

September 8, 1962

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

Negro

7. Married ☒ Never Married ☐

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9/4/1909

9. AGE (last birthday)

53

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Custodian

10b. KIND OF BUSINESS OR INDUSTRY

Bd. of Religious Org.

11. BIRTHPLACE (City and state or country)

Quito, Mississippi

12. CITIZEN OF WHAT COUNTRY

U. S. A.

13a. FATHER'S NAME

MARSHALL WASHINGTON

13b. MOTHER'S MAIDEN NAME

ELEANOR SIMMONS

14. NAME OF HUSBAND OR WIFE

NINA WASHINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address E. St. Louis,

Janie Reese, 2936 Louisiana Blvd., Ill.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Complete heart block

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Coronary Artery Disease

DUE TO (c)

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐

NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

806 A

and last saw her alive on

Death occurred at

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

9/13/62

23c. NAME OF CEMETERY OR CREMATORY

Sunset Gardens of Memory

23d. LOCATION (City, town, or county)

Stookey Township, Illinois

24. FUNERAL DIRECTOR

ADDRESS

2111 Missouri Ave.

25. DATE RECD. BY LOCAL REG.

SEP 10 1962

26. REGISTRAR'S SIGNATURE

Dean Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marion C. Offies

Licensed Embalmer No. 5177

P. O. Address St. Louis, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license)
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.